State Approaches to Children's System of Care Development

Presented by: Kevin Martone & Kelly English
Technical Assistance Collaborative, Inc.
October 1, 2013
Iowa Department of Human Services
Children's Disability Services Workgroup

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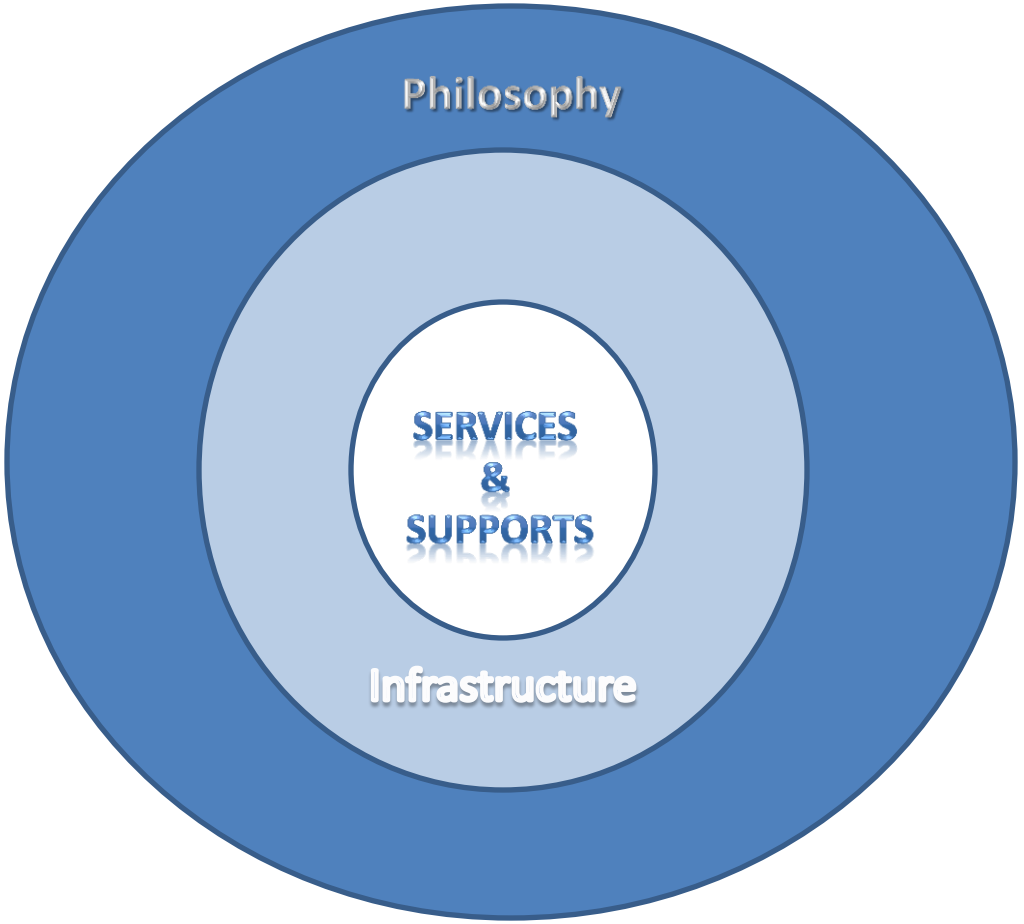
System of Care Framework



Stroul, B. (2002). Systems of care: A framework for system reform in children's mental health [Issue Brief]. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

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Systems of Care as System Reform

From	To
• Fragmented service delivery	• Coordinated service delivery
• Categorical programs/funding	• Multidisciplinary teams and blended resources
• Limited service availability	• Comprehensive service array
• Reactive, crisis-oriented approach	• Focus on prevention/early intervention
• Focus on deep end, restrictive settings	• Least restrictive settings
• Children out-of-home	• Children within families
• Centralized authority	• Community-based ownership
• Creation of dependency	• Creation of self-help and active participation
• Child-only focus	• Family as focus
• Needs/deficits assessments	• Strengths-based assessments
• Families as problems	• Families as partners and therapeutic allies
• Cultural blindness	• Cultural competence
• Highly professionalized	• Coordination with informal and natural supports
• Child and family must “fit” services	• Individualized/wraparound approach
• Input-focused accountability	• Outcome/results-oriented accountability
• Funding tied to program	• Funding tied to populations

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From: Pires, S. (1996). Characteristics of systems of care as systems reform initiatives. Washington, DC: Human Service Collaborative

State Approaches to System of Care

MARYLAND

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Mission/Vision

- Vision (Children's Cabinet): *All Maryland's children will be successful in life.*
- Vision (Gov's Office for Children): *Maryland will achieve child well-being through interagency collaboration and state/local partnerships.*
- Mission: *The Children's Cabinet, led by the Executive Director of the Governor's Office for Children, will work collaboratively to create and promote an integrated, community-based service delivery system for Maryland's children, youth, and families. Our mission is to improve the well-being of Maryland's children.*

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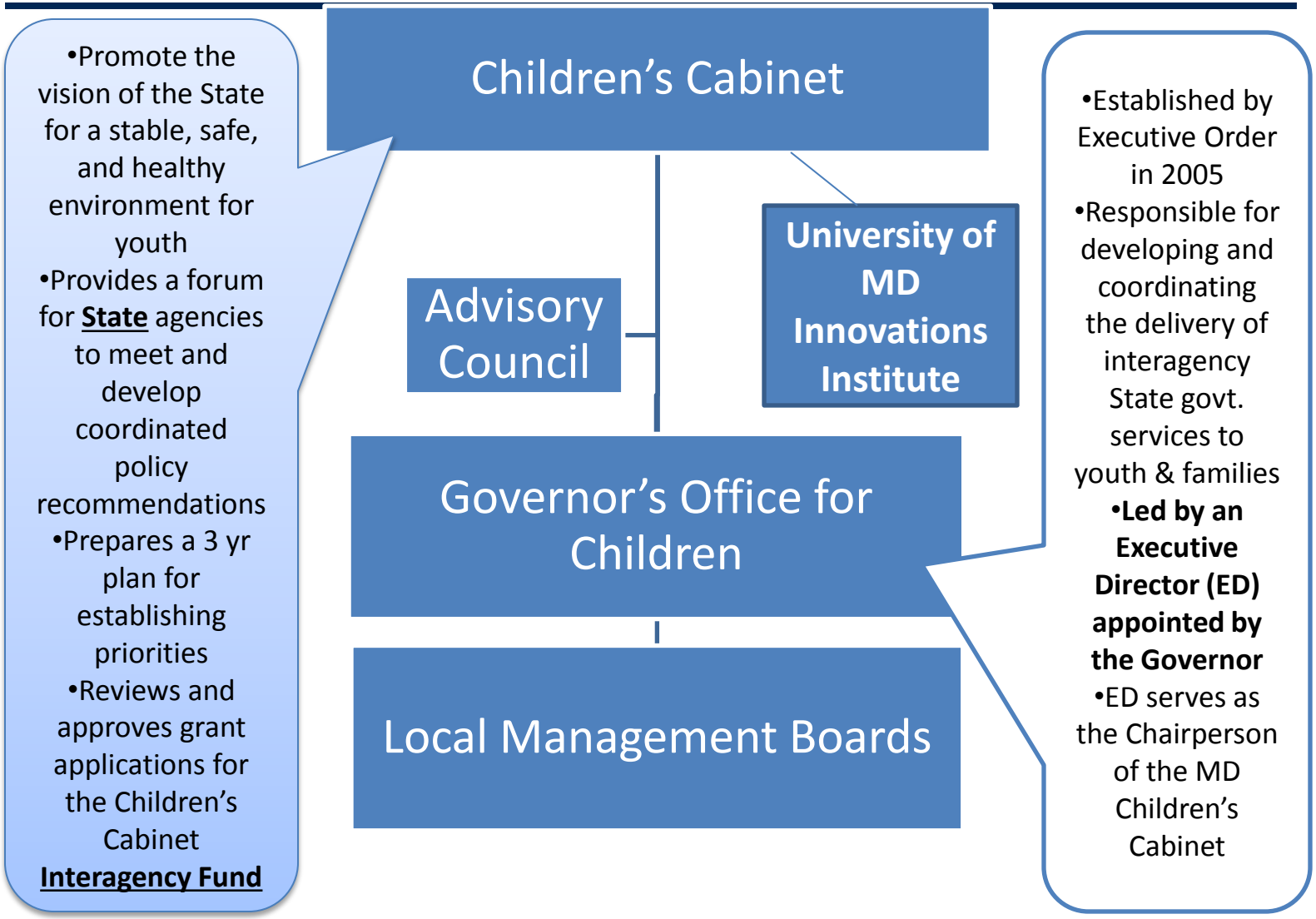
Maryland: Organizing structure



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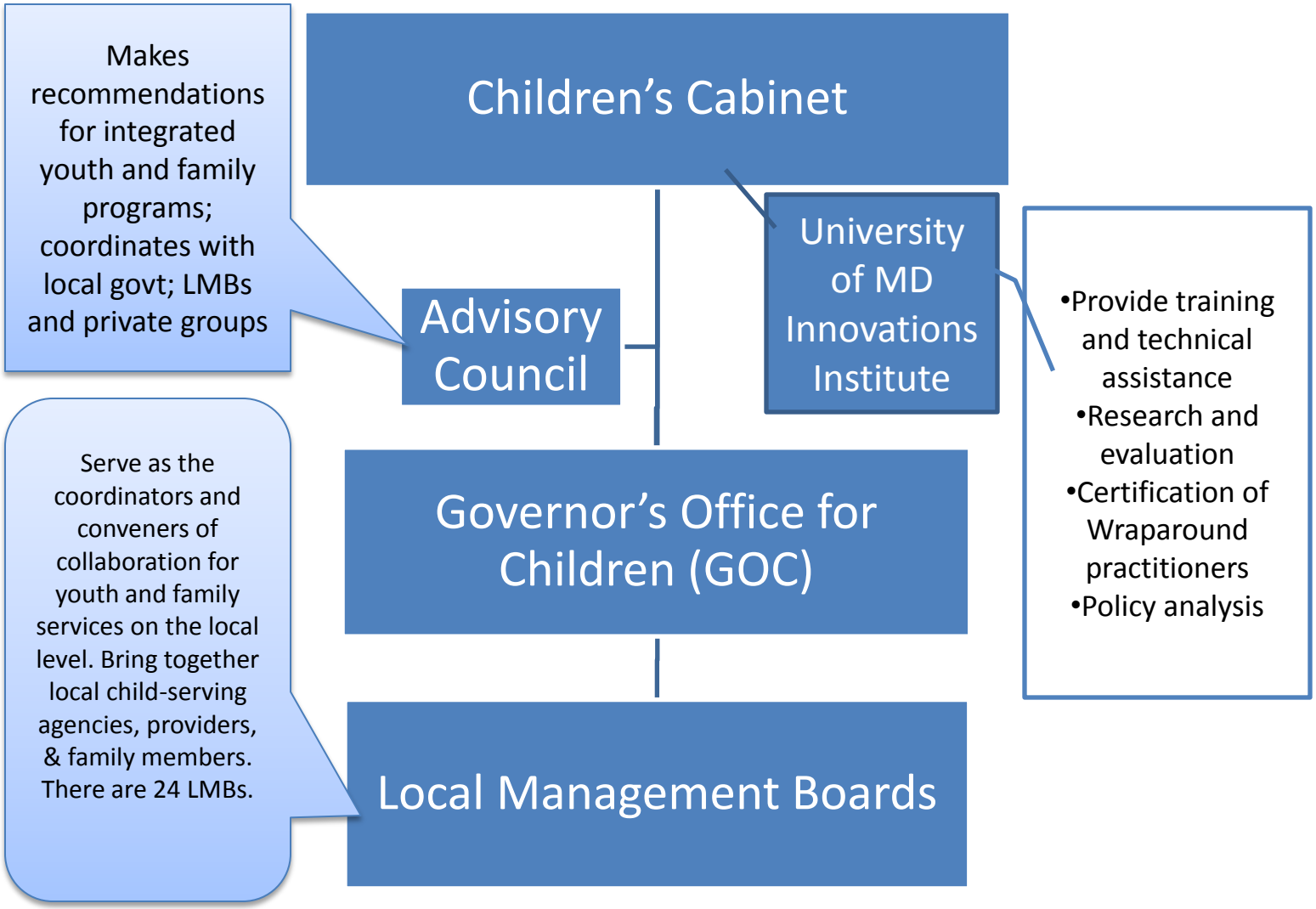
Maryland: Organizing structure



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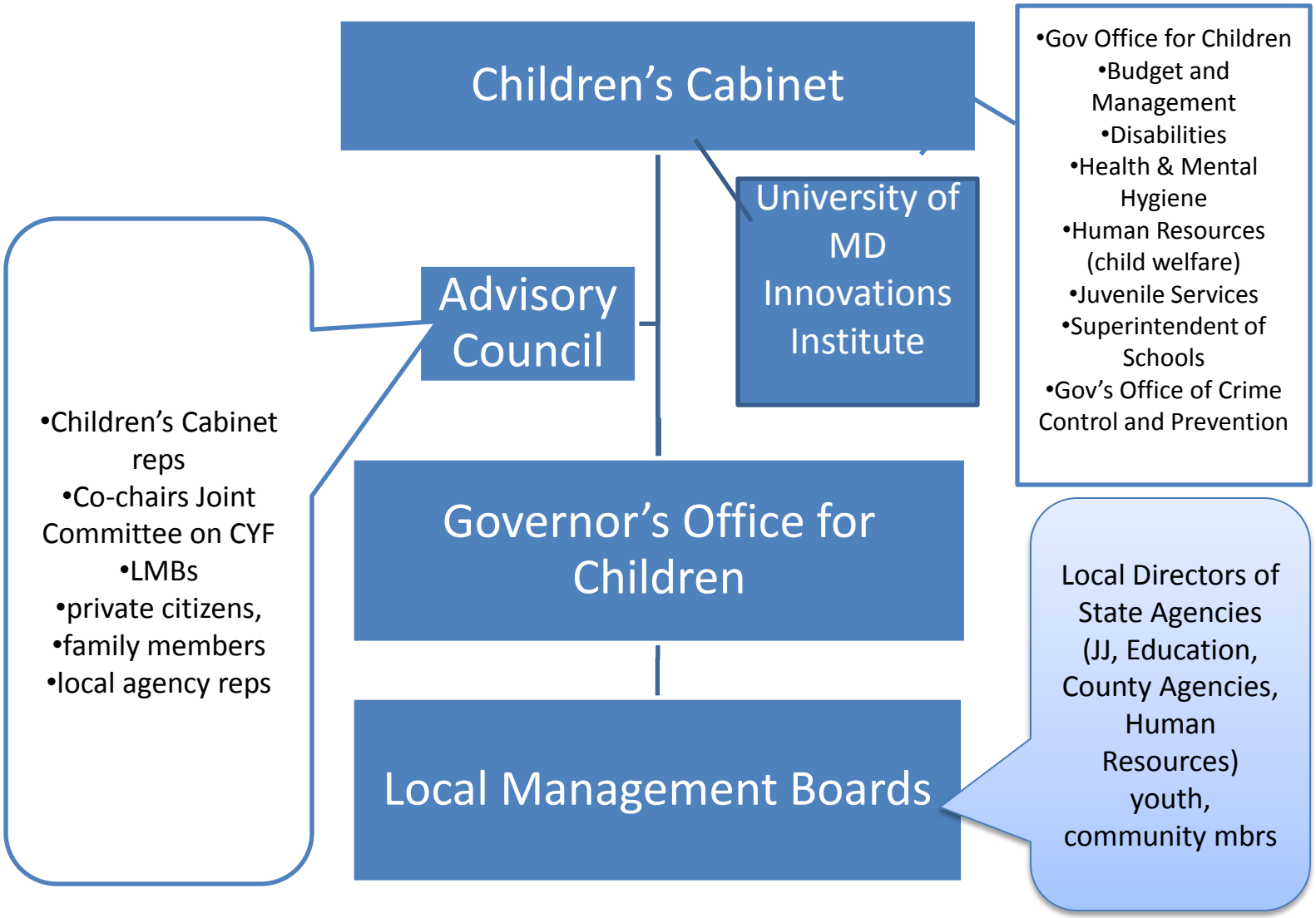
Maryland: Organizing structure



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Maryland: Care Management Entity

- In January 2012, GOC issued an RFP to select a statewide care management entity (CME) to serve certain youth with intensive needs

Organization/Entity	N of youth
Department of Juvenile Services (DJS)	75
Department of Human Resources (DHR)	75
MD CARES & RURAL CARES (SAMHSA SOC grants)	40 (will reduce over time)
1915 (c) PRTF Waiver	200 (will reduce over time)
Interim Case Service Account	5 (will reduce over time)

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Maryland: Care Management Entity

- The CME will:
  - Provide intensive care coordination using a Wraparound service delivery model
  - Provide access to family support and youth support partners via a subcontract with family organization
  - Facilitate access to community-based service and supports available through LMBs and other community resources
  - Administer discretionary (flexible) funds and contract for services as needed
  - Conduct assessments
  - Conduct quality assurance and monitor outcomes

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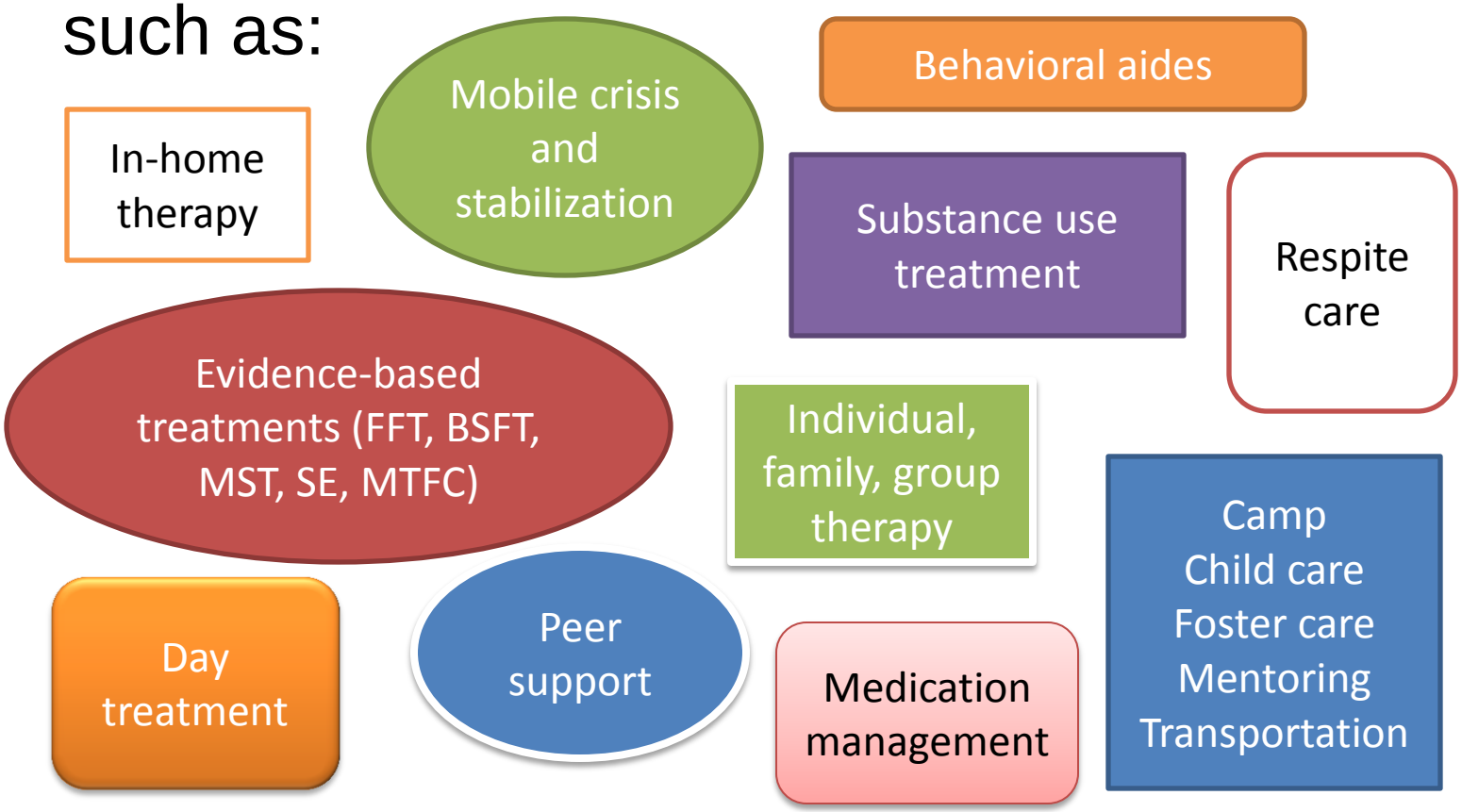
Services and supports

- CME facilitates linkages to and contracts (as needed) with community resources such as:



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Care Management Entity: Financing

CME is paid a case rate

- GOC (Children's Cabinet) – general funds
- Medicaid administrative claiming for waiver enrollees
- DHR – general funds
- DJS – general funds
- SAMHSA Systems of Care grant funds

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Care management for youth with SED

- Recently submitted a 1915(i) State Plan Amendment (out for public comment 9/17/13)
- Eligibility limited to Medicaid eligible youth with serious emotional disturbance with significant functional impairment
- Care coordination using Wraparound process via Care Coordination Organization (aka CME)

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Care management for youth with SED

- New services under draft 1915(i) SPA that will be *coordinated* via the CCO
  - Child and Family Team (CFT) participation
  - Intensive In-Home Services
    - Must be an Evidence-based or promising practice approved by DHMH
  - Mobile Crisis Response
  - Community-Based Respite
  - Out-of-Home Respite
  - Peer-to-Peer Support (provided by a Family Support Organization)
  - Expressive and Experiential Behavioral Services
  - Mental Health Consultation to Health Care Professionals
  - Customized Goods and Services

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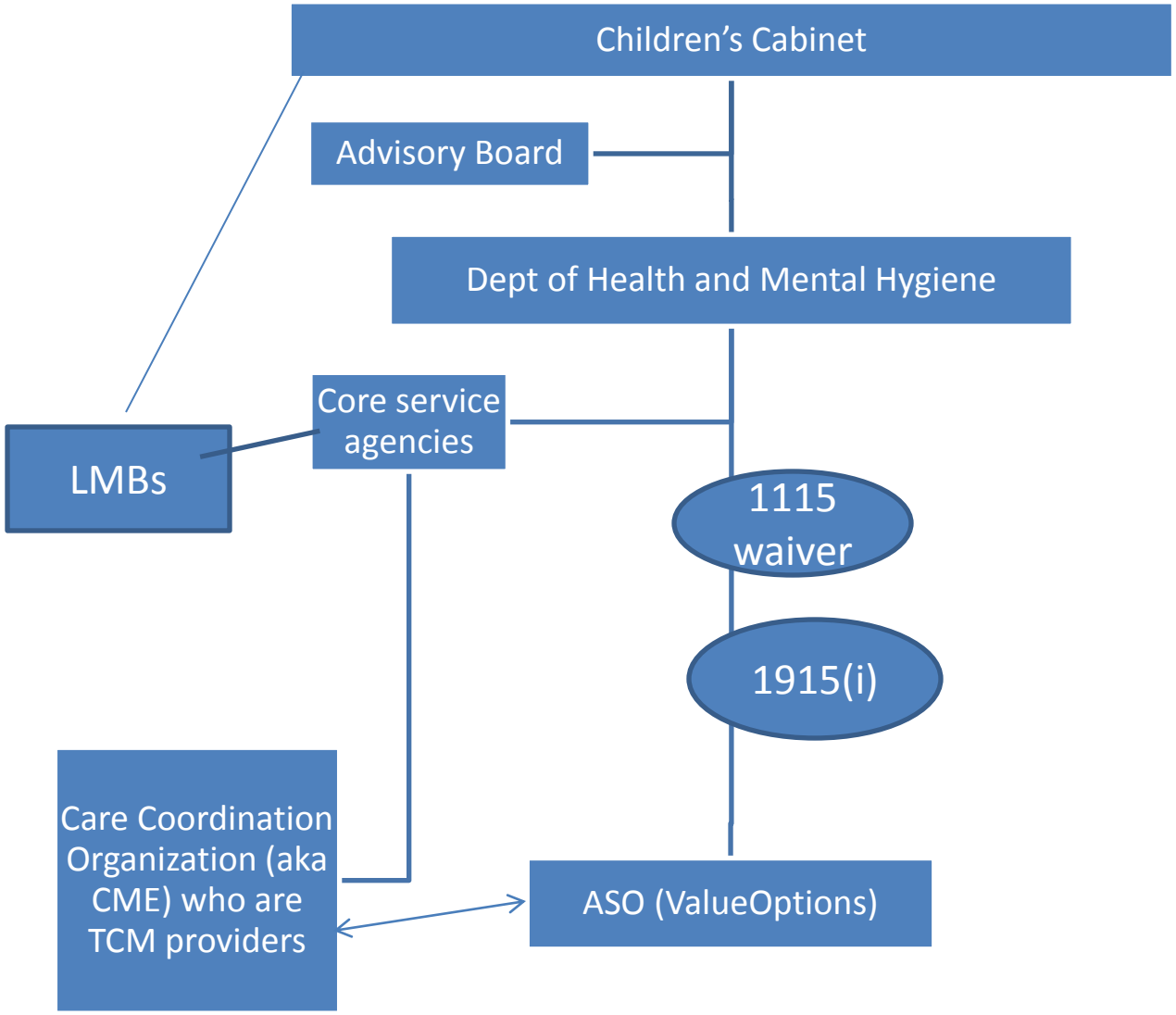

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Maryland's SOC Approach

- Strengths
  - Coordination of youth-serving agencies at the Governor's Office level
  - Funding to support services at the local level available through Children's Cabinet Interagency Fund
  - Long history of commitment to SOC values
  - Care coordination available for youth with Medicaid and non-Medicaid enrolled youth
  - Broad array of services and supports available including family and youth support
  - University of MD provides training, certification, consultation, policy analysis, research, and evaluation

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Maryland's SOC approach

- Challenges
  - Different populations of youth served in different CMEs
  - CME/CMOs are not a purchaser of services (with exception of some discretionary funds) and do not authorize care

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State Approaches to System of Care

MASSACHUSETTS

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Legal action as change agent

- *Rosie D. v. Patrick*, a class action lawsuit filed in 2001 on behalf of children and youth with serious emotional disturbance
- Alleged that MA Medicaid failed to meet obligations of the EPSDT statute
- January 2006, the Court found that MA Medicaid had not provided sufficient:
  - Behavioral health screening in primary care
  - Behavioral health assessments
  - Service coordination
  - Home-based behavioral health services
- Final judgment issued June 2007, with implementation of care coordination and home-based services beginning July 2009
- Medicaid as the sole financer-no blending/braiding with other state systems

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Legal action as change agent

- Medicaid as the sole financer-no blending/braiding with other state systems
- Final judgment issued June 2007, with implementation of care coordination and home-based services beginning July 2009
  - Intensive care coordination (Wraparound)
  - Family support and training (Family Partners)
  - Mobile crisis intervention
  - In-home therapy
  - In-home behavioral therapy
  - Therapeutic mentoring

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Children's Behavioral Health Initiative Governance

- Staff positions created at Executive Office of Health and Human Services level to:
  - Coordinate interagency (child welfare, mental health, public health, juvenile justice, education) activities
    - Develop referral and collaboration protocols
  - Facilitate compliance with state's remedial plan and serve as the liaison for the federal court monitor
  - Collaborate with MassHealth Office of Behavioral Health and other stakeholders
- Children's Behavioral Health Advisory Council
  - Established via statute
  - Membership consists of Commissioners of child-serving state agencies, education, providers, family members, trade organization reps, academics, and managed care reps
  - Required to submit an annual report, with legislative and regulatory recommendations to the governor, secretary of health and human services, the commissioner of early education and care, the commissioner of elementary and secondary education, the child advocate and the general court

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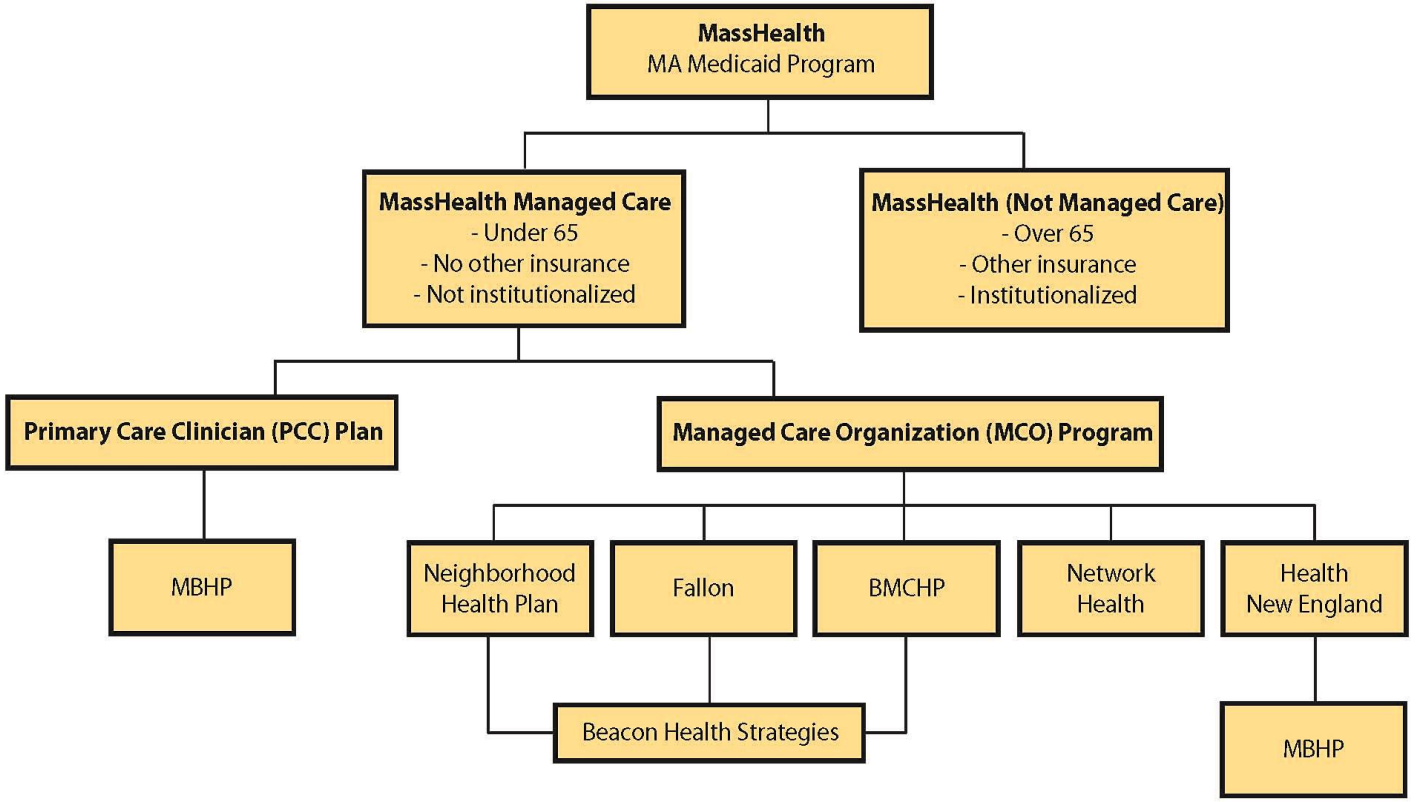
MassHealth Organizational Chart



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Community Service Agencies

- Managed care entities contract with 32 CSAs -- one for each service area (29) and three culturally- and linguistically-focused CSAs
- Deliver Intensive Care Coordination and Family Support and Training using the Wraparound care coordination model
- Convene and staff the local System of Care Committee
  - Local state agency reps (e.g. mental health, child welfare, JJ)
  - Local service providers
  - Community organizations and businesses
  - Family and youth

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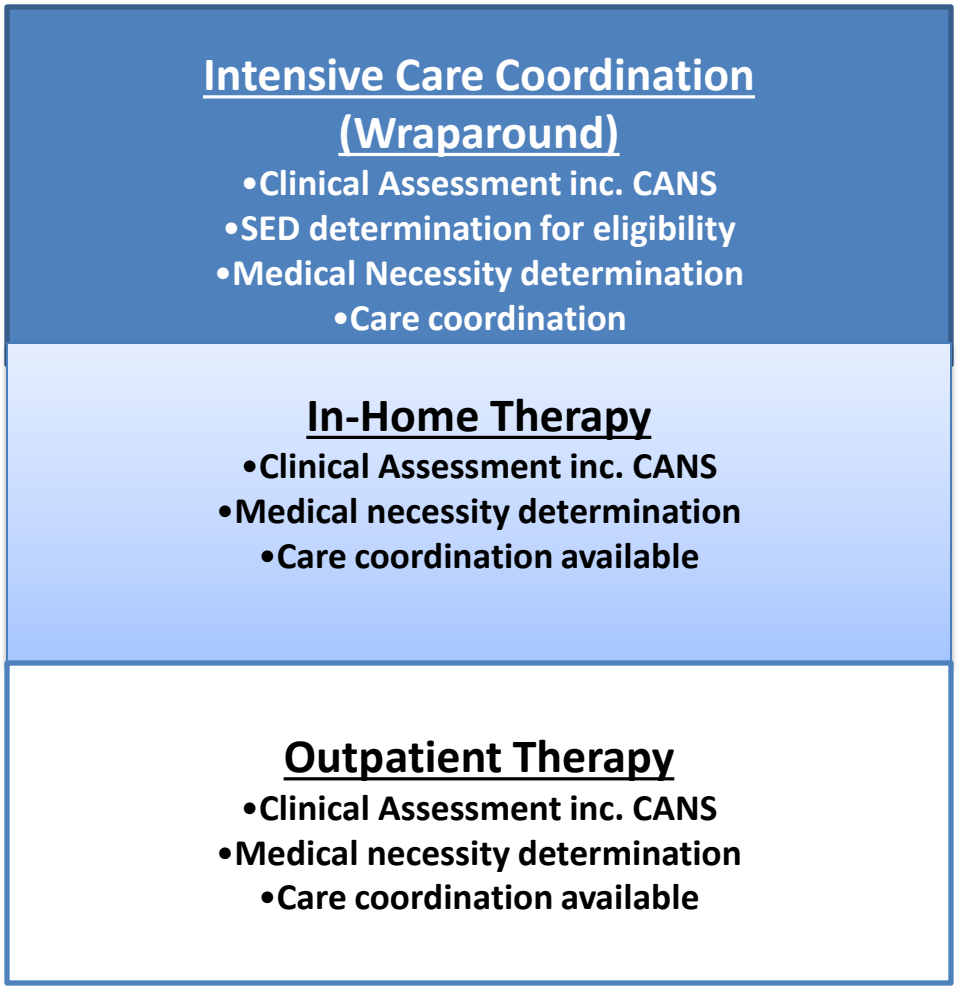
Care Coordination for youth with varying needs: Clinical Hubs



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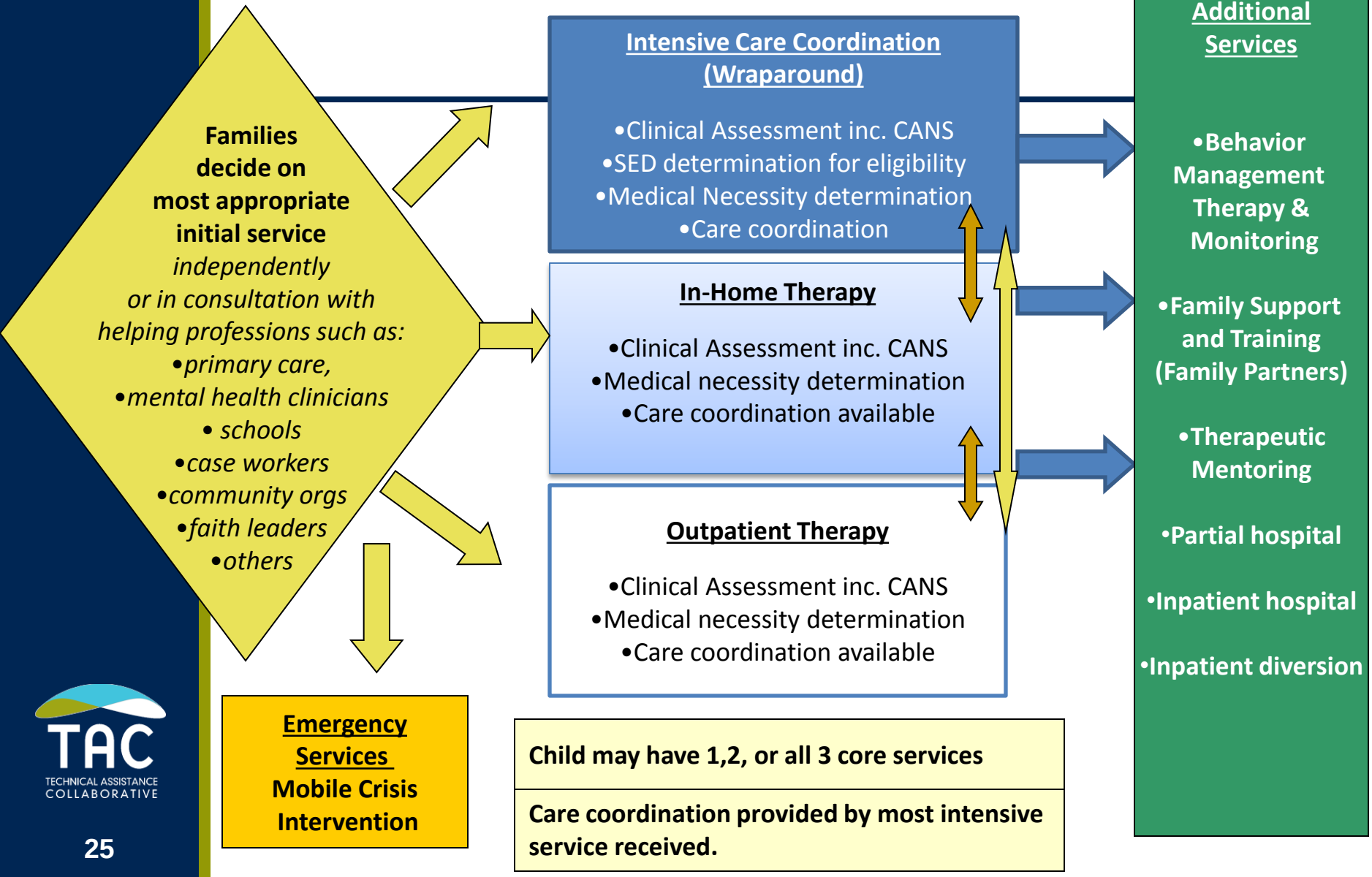
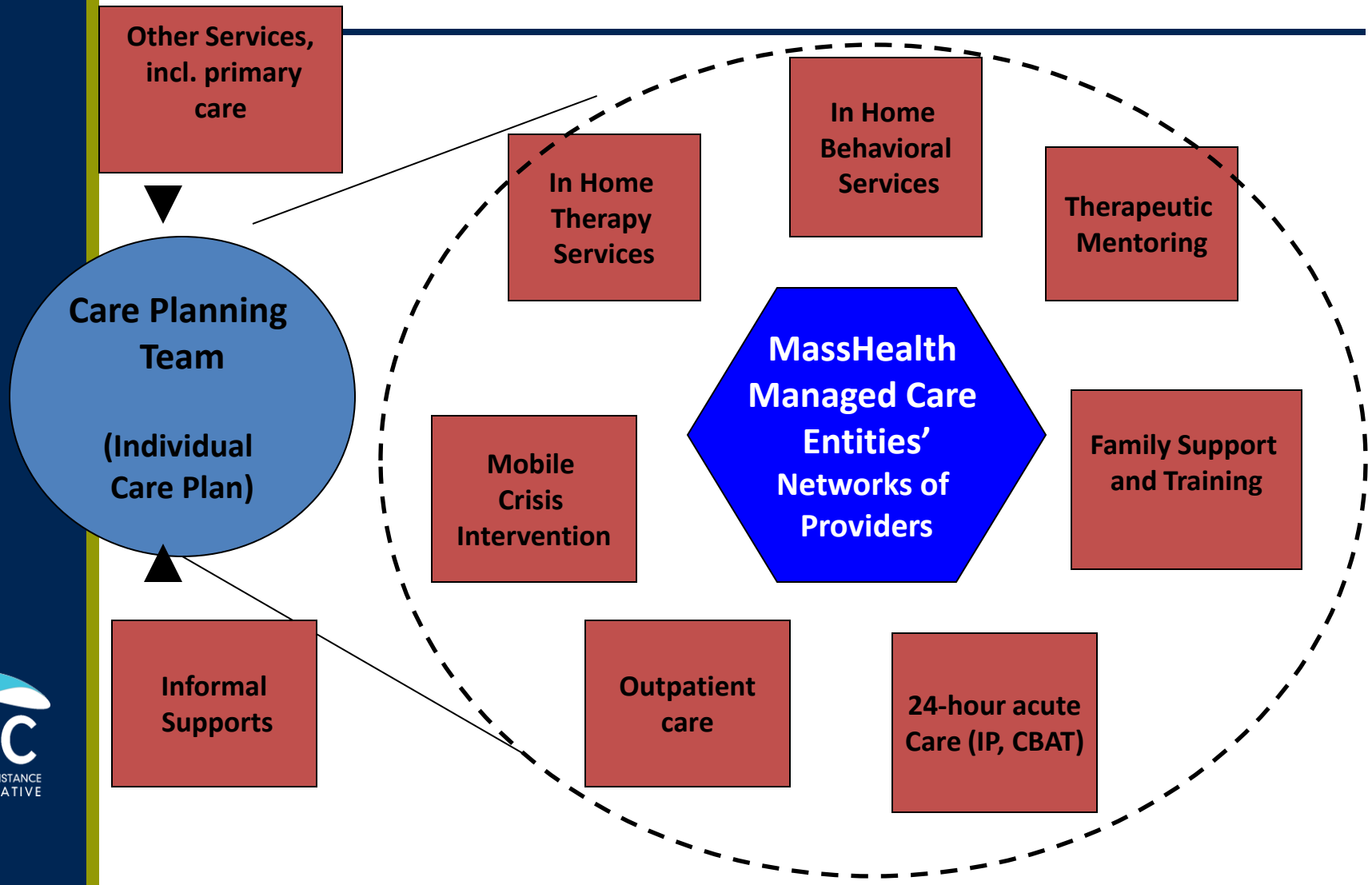
Care Coordination



Provider Network



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Massachusetts SOC approach

- Strengths
  - Use of evidence-based care coordination model in Wraparound
  - Care coordination available for youth with different intensities of need
  - Strong array of Medicaid behavioral health services and supports
  - Sustainable funding stream through Medicaid state plan
  - “No wrong door” entry for youth
  - Statewide service access
  - Common assessment used across all service providers

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Massachusetts SOC approach

- Challenges
  - No access to state financed flexible dollars to support supports identified in a plan of care for a youth
  - Care coordination for non-Medicaid enrolled youth is fragmented across state agencies
  - Neither CSAs (nor the MCEs) purchase or authorize non-Medicaid services or supports making it difficult to leverage these supports on behalf of youth
  - Six MCEs with differing authorization and billing practices places administrative burden on providers
  - Continuity of care can be a challenge when a youth loses MassHealth

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State Approaches to System of Care

NEW JERSEY

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Governance

- Department of Children and Families
  - Child Protection and Permanency
  - Children's System of Care
  - Family and Community Partnerships
  - Women
  - Adolescent Services
  - Advocacy
  - Education
  - Licensing
  - Performance Management and Accountability
  - Institutional Abuse Investigation Unit

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Division of Children's System of Care

- Serves youth with:
  - Emotional and behavioral health care challenges
  - Developmental and intellectual disabilities
    - Responsible for determining eligibility for developmental disability services of children under age 18.
  - Serves Medicaid and non-Medicaid eligible youth

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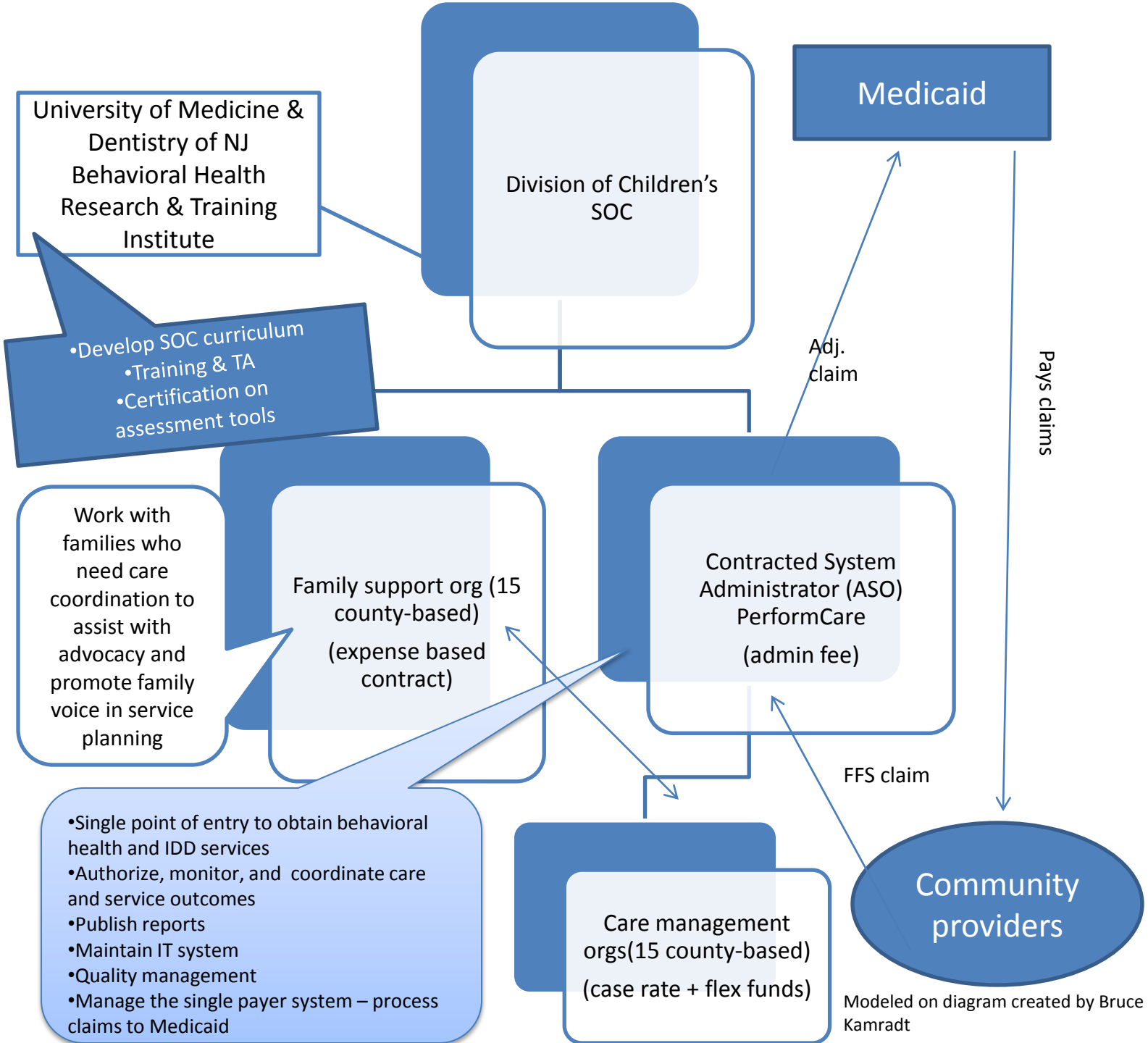
University of Medicine & Dentistry of NJ Behavioral Health Research & Training Institute
Division of Children's SOC
Medicaid
•Develop SOC curriculum
•Training & TA
•Certification on assessment tools
Adj. claim
Pays claims
Work with families who need care coordination to assist with advocacy and promote family voice in service planning
Family support org (15 county-based)
(expense based contract)
Contracted System Administrator (ASO) PerformCare
(admin fee)
FFS claim
•Single point of entry to obtain behavioral health and IDD services
•Authorize, monitor, and coordinate care and service outcomes
•Publish reports
•Maintain IT system
•Quality management
•Manage the single payer system – process claims to Medicaid
Care management orgs(15 county-based)
(case rate + flex funds)
Community providers
Modeled on diagram created by Bruce Kamradt

Services and supports

- In addition to care coordination
  - Mobile crisis response
  - Intensive in-home therapy
  - Therapeutic foster care
  - Functional family therapy
  - Behavioral aides
  - Multi-systemic therapy
  - Group homes
  - Residential care
  - Flexible funding available to pay for good and services identified in a plan of care for a youth

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Financing

- Mental health
- Child welfare
- Developmental disabilities
- Medicaid
  - Administrative funds
  - Rehab Option
  - EPSDT
  - Targeted Case Management

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Single payer system

- CMOs and Mobile Crisis Response providers can make Medicaid presumptive eligibility determinations
- Blended funding from DCF to Medicaid to administer and pay claims
- Created a Medicaid “look-alike” program to cover services for non-Medicaid enrolled youth
- Providers reimbursed at same rate for Medicaid and non-Medicaid youth
- Providers submit all claims to the CSA (ASO)

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NJ SOC approach

- Strengths
  - Single payer system
  - Single point of entry
  - Services available to Medicaid and non-Medicaid enrolled youth
  - Training and research infrastructure to support best practice service delivery
  - Training and technical assistance infrastructure
  - Flexible funding available to support needs identified in a youth's plan of care

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NJ SOC approach

- Challenges
  - FSOs disconnected with service delivery -- serving as advocates as opposed to a peer support service
  - Heavy reliance on Medicaid funding makes it challenging to focus on other “non-billable” activities such as training, quality improvement, etc.

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Technical Assistance Collaborative, Inc. – TAC

@TACIncBoston

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